



## Electronic Data Interchange (EDI) Trading Partner Profile - Provider

State Form 51401 (7-03)  
Indiana State Department of Health

### Provider of Service:

Name: \_\_\_\_\_

Address (include Suite): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

### Software Vendor (please complete this section if you will be using software, either purchased or developed internally, to transmit transactions directly to ISDH):

\_\_\_\_\_ Purchased (please complete the information below) \_\_\_\_\_ Developed in-house (do not complete below)

Name: \_\_\_\_\_

Address (include Suite): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

### Data Transmission / Retrieval Method (please complete if you will be submitting transactions directly from your office to ISDH):

\_\_\_ Asynchronous Dial-up

\_\_\_ FTP via PPP Dial-up Connection

**Billing Service, or Clearinghouse Information (please complete this section if you are using a billing service or clearinghouse to submit transactions to the ISDH. Please forward the enclosed Trading Partner Profile-Billing Service/Clearinghouse and Trading Partner Agreement to your intermediary for them to complete):**

Name: \_\_\_\_\_

Address (include Suite): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

<b>Indicate your request(s) for the EDI transactions below.</b>
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**Inbound (sent from you to ISDH):**

- ☐ Health Care Claim (837)
- ☐ Prior Authorization (278)
- ☐ Eligibility Request (270)
- ☐ Claim Status Request (276)
- ☐ Retail Pharmacy Prior Authorization (NCPDP)
- ☐ Retail Pharmacy Claim (NCPDP)
- ☐ Retail Pharmacy Eligibility Request (NCPDP)

**Outbound (sent from ISDH to you):**

- ☐ Payment Advice (835)
- ☐ Prior Authorization (278)
- ☐ Eligibility Request (271)
- ☐ Claim Status Request (277)
- ☐ Retail Pharmacy Prior Authorization (NCPDP)
- ☐ Retail Pharmacy Eligibility Request (NCPDP)

Remittance Advices are provided on a weekly basis ONLY and include claims submitted electronically and on paper.

<b>Outbound Transaction Transmission</b>
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All outbound transmissions indicated above will be sent to the provider of service. If you want outbound transactions to be sent via a clearinghouse or billing service, please initial below.

I am authorizing the outbound transactions indicated to be sent to my intermediary listed on page 1

\_\_\_\_\_  
Provider's Initials

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title of Authorized Signatory

Remittance Address:  
ISDH  
Office of HIPAA Compliance  
EDI Provider Relations, 3K  
2 North Meridian Street  
Indianapolis, IN 46204-3010  
317-233-9803